

# NATIONAL TRANSPORTATION SAFETY BOARD PILOT/OPERATOR AIRCRAFT ACCIDENT/INCIDENT REPORT

This form to be used for reporting civil and public use aircraft accidents and incidents

## BASIC INFORMATION

### Accident/Incident Location

Nearest City/Place: KOTLIK State: AK  
ZIP: 99620 Country: USA  
Latitude: \_\_\_\_\_ (dd:mm:ss N/S) Longitude: \_\_\_\_\_ (ddd:mm:ss E/W)

### Date/Time

Date: 07/06/2012 Local Time: 13:30  
*mm/dd/yyyy* Time Zone: AK

### Phase of Operation

☐ Standing ☐ Takeoff (incl. initial climb) ☒ Cruise ☐ Hover  
☐ Taxi ☐ Climb ☐ Maneuvering ☐ Other  
☐ Descent ☒ Landing ☐ Approach ☐ Unknown

### Collision with Other Aircraft

☐ Midair  
☐ On-ground  
☒ None

### Altitude of In-Flight Occurrence

0 ft MSL

## AIRCRAFT INFORMATION

Manufacturer: CESSNA

Model: 207A

Serial Number: 20700575

Registration Number: N2162C

Amateur-built: ☐ Yes ☒ No

Max Gross Weight: 3,800 lbs

Weight at Time of Accident/Incident: 2,800 lbs

Location of Center of Gravity at Time of Accident/Incident:

38 inches from ☐ nose or ☒ datum  
-or- \_\_\_\_\_ Percent Mean Aerodynamic Cord (% MAC)

### Category of Aircraft

☒ Airplane  
☐ Balloon  
☐ Blimp/Dirigible  
☐ Glider  
☐ Gyrocraft  
☐ Helicopter  
☐ Powered lift  
☐ Ultralight  
☐ Unknown

### Type of Airworthiness Certificate (Check all that apply)

**Standard** ☒ Normal ☐ Utility ☐ Acrobatic ☐ Transport  
**Special** ☐ Restricted ☐ Limited ☐ Provisional ☐ Experimental ☐ Special Flight ☐ Light Sport

Number of Seats: 7

If Large Aircraft, how many seats for:

Flight Crew: \_\_\_\_\_

Cabin Crew: \_\_\_\_\_

Passengers: \_\_\_\_\_

Landing Gear ☐ Retractable

Check any additional landing gear configuration that applies:

☒ Tricycle ☐ Tailwheel  
☐ Amphibian ☐ High Skid  
☐ Emergency Float ☐ Skid  
☐ Float ☐ Ski  
☐ Hull ☐ Ski/Wheel  
☐ Unknown

### Type of Maintenance Program

☐ Annual  
☐ Conditional (Amateur-built only)  
☐ Manufacturer's Inspection Program  
☒ Other Approved Inspection Program (AAIP)  
☐ Continuous Airworthiness  
☐ Other, specify: \_\_\_\_\_

### Last Inspection Type

☐ 100 Hour ☐ Continuous Airworthiness  
☒ AAIP ☐ Conditional Inspection  
☐ Annual ☐ Unknown

Date Last Inspection: 06/30/2012

*mm/dd/yyyy*

Airframe Total Time: 21,585 hrs

hours measured at (check one)

☒ Last Inspection ☐ Time of Accident/Incident

### IFR Equipped

☐ Yes ☒ No ☐ Unknown

### Stall Warning System Installed

☒ Yes ☐ No ☐ Unknown

### Type of Fire Extinguishing System

☐ None  
☒ Specify HALON HAND HELD

### ELT Installed

☒ Yes ☐ No

### ELT Activated

☒ Yes ☐ No

ELT Manufacturer: Artex

Model/Series: ME 406

Serial Number: ADCC40A688002F1

Battery Type: ME406

Battery Exp. Date: 7/2015

### Engine Type

☒ Reciprocating ☐ Turbo Jet  
☐ Turbo Shaft ☐ Turbo Fan  
☐ Turbo Prop ☐ Unknown

### Reciprocating Fuel System Type

☐ Carburetor  
☒ Fuel Injected

### Propeller

☐ Fixed Pitch  
☒ Controllable Pitch

Manufacturer: HARTZELL

Model: PHC-C3YF-1RF

| Engine | Engine Manufacturer | Engine Model/Series | Manufacturer's Serial Number | Date of Mfg.<br><i>mm dd yyyy</i> | Engine Rated Power Measured as (check one)<br><input checked="" type="checkbox"/> Horsepower or <input type="checkbox"/> lbs of Thrust | Total Time (hours) | Time Since Inspection (hours) | Time Since Overhaul (hours) |
|--------|---------------------|---------------------|------------------------------|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--------------------|-------------------------------|-----------------------------|
| Eng. 1 | CONTINENTAL         | IO-520-F27          | 1006607                      | 11/08/2011                        | 300                                                                                                                                    | 464                | 15                            | 464                         |
| Eng. 2 |                     |                     |                              |                                   |                                                                                                                                        |                    |                               |                             |
| Eng. 3 |                     |                     |                              |                                   |                                                                                                                                        |                    |                               |                             |
| Eng. 4 |                     |                     |                              |                                   |                                                                                                                                        |                    |                               |                             |

| OWNER/OPERATOR INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Registered Aircraft Owner</b><br>Name: <u>GRANT AVIATION, INC</u><br>Fractional Ownership Aircraft: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Owner Address</b><br>City: <u>ANCHORAGE</u><br>State: <u>AK</u> ZIP: <u>99509</u><br>Country: <u>USA</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                   |
| <b>Operator of Aircraft</b> <input checked="" type="checkbox"/> Same As Registered Owner<br>Name: _____<br>Doing Business As: _____<br>Air Carrier/Operator Designator (4 Character Code): _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Operator Address</b> <input checked="" type="checkbox"/> Same As Registered Owner<br>City: _____<br>State: _____ ZIP: _____<br>Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |
| <b>Regulation Flight Conducted Under</b><br><input checked="" type="checkbox"/> FAR 91 <input type="checkbox"/> FAR 129 <input type="checkbox"/> FAR 91 Special Flight <input type="checkbox"/> Public Use (select type)<br><input type="checkbox"/> FAR 103 <input type="checkbox"/> FAR 133 <input type="checkbox"/> Non-US, Commercial <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Local<br><input type="checkbox"/> FAR 121 <input type="checkbox"/> FAR 135 <input type="checkbox"/> Non-US, Non-commercial <input type="checkbox"/> Unknown<br><input type="checkbox"/> FAR 125 <input type="checkbox"/> FAR 137 <input type="checkbox"/> Armed Forces |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Revenue Sightseeing Flight</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><hr/> <b>Air Medical Flight</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                   |
| <b>Purpose of Flight</b><br>for FAR 91, 103, 133, 137 (Select one)<br><input type="checkbox"/> Personal<br><input type="checkbox"/> Business<br><input type="checkbox"/> Executive/Corporate<br><input type="checkbox"/> Other Work Use<br><input type="checkbox"/> Instructional<br><input type="checkbox"/> Ferry<br><input checked="" type="checkbox"/> Positioning<br><input type="checkbox"/> Aerial Application<br><input type="checkbox"/> Aerial Observation<br><input type="checkbox"/> Air Drop<br><input type="checkbox"/> Air Race / Show<br><input type="checkbox"/> Flight Test<br><input type="checkbox"/> Public Use<br><input type="checkbox"/> Unknown                                  | <b>Revenue Operation</b><br>for FAR 121, 125, 129, 135 (Select one)<br><input type="checkbox"/> Scheduled or Commuter<br><input type="checkbox"/> Non-Scheduled or Air Taxi<br><hr/> <b>Domestic or International</b><br><input type="checkbox"/> Domestic <input type="checkbox"/> International<br><hr/> <b>Cargo Operation</b><br><input type="checkbox"/> Passenger/Cargo<br><input type="checkbox"/> Passenger _____ How many?<br><input type="checkbox"/> Cargo _____ lbs<br><input type="checkbox"/> Mail | <b>Type of Commercial Operating Certificate Held</b><br>(Select all that apply)<br><input type="checkbox"/> None<br><input type="checkbox"/> Flag Carrier Operating Certificate (121)<br><input type="checkbox"/> Supplemental<br><input type="checkbox"/> Air Cargo<br><input type="checkbox"/> Foreign Air Carriers (129)<br><input checked="" type="checkbox"/> Commuter Air Carrier (135)<br><input type="checkbox"/> On-Demand Air Taxi (135)<br><input type="checkbox"/> Large Helicopter (127)<br><input type="checkbox"/> Rotorcraft External Load (133)<br>- or -<br><input type="checkbox"/> Agricultural Aircraft (137)<br><input type="checkbox"/> Other Operator of Large Aircraft |                                                                                                                                                   |
| OTHER AIRCRAFT COLLISION (If an on ground collision occurred, complete this section for other aircraft)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                   |
| <b>Aircraft Registration Number</b><br>_____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Manufacturer:</b> _____<br><b>Model:</b> _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Damage to Other Aircraft</b><br><input type="checkbox"/> Destroyed <input type="checkbox"/> Minor<br><input type="checkbox"/> Substantial <input type="checkbox"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                   |
| <b>Registered Owner of Other Aircraft</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                   |
| <b>Pilot of Other Aircraft</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                   |
| MECHANICAL MALFUNCTION/FAILURE (If more space is needed, continue on separate sheet)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                   |
| <b>Was there Mechanical Malfunction/Failure?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown<br>(If yes, list the name of the part, manufacturer, part no., serial no., and describe the failure.)<br><br><br><br><br>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>Total Time/Cycles On Part</b><br>_____<br>Hours<br>_____<br>Cycles<br><hr/> <b>Time Since This Part Inspected/Overhauled</b><br>_____<br>Hours |
| DAMAGE TO AIRCRAFT AND OTHER PROPERTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                   |
| <b>Aircraft Damage</b><br><input type="checkbox"/> None <input checked="" type="checkbox"/> Substantial<br><input type="checkbox"/> Minor <input type="checkbox"/> Destroyed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Aircraft Fire</b><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Both Ground and In-Flight<br><input type="checkbox"/> In-Flight <input type="checkbox"/> Unknown Origin<br><input type="checkbox"/> On-Ground                                                                                                                                                                                                                                                                          | <b>Aircraft Explosion</b><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Both Ground and In-Flight<br><input type="checkbox"/> In-Flight <input type="checkbox"/> Unknown Origin<br><input type="checkbox"/> On-Ground                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                   |

**Description of Damage to Aircraft and Other Property** (use additional sheet if necessary)

NOSE GEAR IS MISSING FROM THE FORK DOWN. THE STRUT IS FOLDED UP UNDER THE AIRCRAFT. PROP STRIKE. BELLY SKINS DAMAGED. SHEET METAL DAMAGED AT THE FIREWALL. BULKHEAD BEHIND THE MAIN LANDING GEAR DAMAGED.

**AIRPORT INFORMATION** (if the accident/incident occurred on approach, takeoff, or within 3 miles of an airport, complete this section)

Airport Identifier: PFKO Distance From Airport Center: 3 SM  
Airport Name: KOTLIK Direction From Airport: 235 degrees MAG  
Proximity to Airport ☒ Off Airport/Airstrip ☐ On Airport ☐ On Airstrip Airport Elevation: 15 ft. MSL

**Approach Segment** (Select one)

☐ On Instrument Approach ☐ Landing ☐ Base leg ☐ Final ☐ Go Around  
☐ Crosswind ☐ Downwind ☐ Low Approach ☐ Aborted Landing (after touchdown)

**IFR Approach** (Check all that apply)

☒ None ☐ PAR ☐ MLS ☐ Practice  
☐ ADF/NDB ☐ Sidestep ☐ LDA ☐ GPS  
☐ SDF ☐ ILS ☐ ASR ☐ Loran  
☐ VOR/TVOR ☐ Localizer Only ☐ Visual ☐ Unknown  
☐ VOR/DME ☐ LOC-back course ☐ Contact  
☐ TACAN ☐ RNAV ☐ Circling

**VFR Approach** (Check all that apply)

☒ None ☐ Stop and Go  
☐ Traffic Pattern ☐ Touch and Go  
☐ Straight-In ☐ Simulated Forced Landing  
☐ Valley/Terrain Following ☐ Forced Landing  
☐ Go Around ☐ Precautionary Landing  
☐ Full Stop ☐ Unknown

**Runway Information**

Runway ID: 02/20 (L/R/C) Length: 4,422 ft Width: 100 ft

**Runway/Landing Surface** (Check all that apply)

☐ Asphalt ☐ Grass/Turf ☐ Macadam ☐ Water  
☐ Concrete ☒ Gravel ☐ Metal/Wood ☐ Unknown  
☐ Dirt ☐ Ice ☐ Snow

**Condition of Runway/Landing Surface** (Check all that apply)

☒ Dry ☐ Snow-Compacted ☐ Water-Calm  
☐ Holes ☐ Snow-Crusted ☐ Water-Choppy  
☐ Ice Covered ☐ Snow-Dry ☐ Water-Glassy  
☐ Rough ☐ Snow-Wet ☐ Wet  
☐ Rubber Deposits ☐ Soft ☐ Unknown  
☐ Slush Covered ☐ Vegetation

**FLIGHT ITINERARY INFORMATION****Last Departure Point**

Airport ID: PFKO  
City: KOTLIK  
State: AK  
Country: USA

**Time of Departure**

Time: 13:30  
Time Zone: AK

**Destination**

Airport ID: PAEM  
City: EMMONAK  
State: AK  
Country: USA

**Type Flight Plan Filed**

☐ None ☐ VFR/IFR  
☒ Company VFR ☐ IFR  
☐ Military VFR ☐ Unknown  
☐ VFR  
Activated? ☐ Yes ☐ No

**Type of ATC Clearance/Service** (Check all that apply)

☒ None ☐ Special VFR ☐ Special IFR ☐ VFR Flight Following ☐ Cruise  
☐ VFR ☐ IFR ☐ VFR On Top ☐ Traffic Advisory ☐ Unknown / NA

**Airspace where the accident/incident occurred** (Check all that apply)

☐ Class A ☐ Class E ☐ Prohibited Area ☐ Jet Training Area ☐ Special  
☐ Class B ☒ Class G ☐ Restricted Area ☐ TRSA ☐ Air Traffic Control Area  
☐ Class C ☐ Demo Area ☐ Military Operations Area (MOA) ☐ FAR 93 ☐ Unknown  
☐ Class D ☐ Warning Area ☐ Airport Advisory Area

**Aircraft Load Description** (Check all that apply)

☒ None ☐ Towing Glider ☐ Parachutists ☐ Livestock  
☐ Passengers ☐ Towing Banner ☐ Water ☐ Unknown  
☐ Cargo ☐ Other External ☐ Chemical/Fertilizer/Seeds

**FUEL & SERVICES INFORMATION****Fuel on Board at Last Takeoff**

(convert from pounds, as necessary)

40 Gallons

**Fuel Type**

☐ 80/87 ☐ 115/145 ☐ JP3 ☐ Other, specify \_\_\_\_\_  
☒ 100 Low Lead ☐ Jet A ☐ JP4  
☐ 100/130 ☐ Automotive ☐ JP5

**Other Services, if Any, Prior to Departure**

NONE

| EVACUATION OF AIRCRAFT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <b>Was an emergency evacuation of the aircraft performed?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| <b>Method of Exit</b> – Describe how the occupants exited and how many occupants evacuated each location<br>Pilot exited through the crew door on the left hand side of the aircraft.                                                                                                                                                                                                                                                                                                                                                             |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| WEATHER INFORMATION AT THE ACCIDENT/INCIDENT SITE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| <b>Weather Observation Facility</b><br>Facility ID: <u>PAEM</u><br>Observation Time: <u>2236</u><br>Time Zone: <u>ZULU</u><br>Distance from Accident Site: <u>30</u> NM<br>Direction from Accident Site: <u>045</u> degrees MAG                                                                                                                                                                                                                                                                                                                   |                                                                                                   | <b>Source of Weather Information</b><br><i>(Check all that apply)</i><br><input checked="" type="checkbox"/> National Weather Service <input type="checkbox"/> Company<br><input type="checkbox"/> Flight Service Station <input type="checkbox"/> Military<br><input type="checkbox"/> TV/Radio <input type="checkbox"/> Internet<br><input type="checkbox"/> Automated Report <input type="checkbox"/> Unknown<br><input type="checkbox"/> Commercial Weather Service (DUATS)                                                                     |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| <b>Briefing Type/Completeness</b><br><input type="checkbox"/> Full <input type="checkbox"/> Abbreviated<br><input type="checkbox"/> Partial / Limited By Pilot <input checked="" type="checkbox"/> Unknown<br><input type="checkbox"/> Partial / Limited By Briefer <input type="checkbox"/> Not Pertinent                                                                                                                                                                                                                                        |                                                                                                   | <b>Light Condition</b><br><input type="checkbox"/> Dawn <input type="checkbox"/> Dusk <input type="checkbox"/> Dark Night<br><input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Bright Night<br><input type="checkbox"/> Not Reported                                                                                                                                                                                                                                                                  |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| <b>Sky/Lowest Cloud Condition</b><br><input type="checkbox"/> Clear <input type="checkbox"/> Thin Broken<br><input type="checkbox"/> Few <input checked="" type="checkbox"/> Thin Overcast<br><input type="checkbox"/> Partial Obscuration <input type="checkbox"/> Unknown<br><input type="checkbox"/> Scattered                                                                                                                                                                                                                                 |                                                                                                   | <b>Ceiling</b><br><input type="checkbox"/> None (clear) <input type="checkbox"/> Obscured<br><input checked="" type="checkbox"/> Broken <input type="checkbox"/> Indefinite<br><input type="checkbox"/> Overcast <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                   |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| <b>Lowest Cloud Condition Height</b><br><u>2,100</u> ft AGL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   | <b>Ceiling Height</b><br><u>2,100</u> ft AGL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| <b>Wind Direction</b><br><input checked="" type="checkbox"/> Indicated: <u>320</u> degrees MAG<br><input type="checkbox"/> Variable                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   | <b>Wind Speed</b><br>Velocity: <u>9</u> KTS<br>-or-<br><input type="checkbox"/> Calm<br><input type="checkbox"/> Light and Variable                                                                                                                                                                                                                                                                                                                                                                                                                 |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| <b>Wind Gusts</b><br>Velocity: _____ KTS<br><input type="checkbox"/> Gusting<br><input checked="" type="checkbox"/> Not Gusting                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   | <b>Type of Turbulence</b> <i>(Check all that apply)</i><br><input checked="" type="checkbox"/> None <input type="checkbox"/> In Clouds<br><input type="checkbox"/> Clear Air <input type="checkbox"/> Vicinity of Thunderstorm<br><b>Severity of Turbulence</b><br><input type="checkbox"/> Extreme <input type="checkbox"/> Moderate <input type="checkbox"/> Light<br><input type="checkbox"/> Severe <input type="checkbox"/> Moderate Chop                                                                                                      |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| <b>NOTAMS (D, L and FDC), AIRMETs, SIGMETs, PIREPs in effect at the time of the accident/incident</b><br>FOR PFKO<br>IENA 04/047 2A9 AD AMB OTS<br><br>FOR PAEM<br>!ENM 06/013 ENM RWY 34 VASI OTS<br>!ENM 06/012 ENM RWY 16 VASI OTS<br>!ENM 06/011 ENM TWY ALL SOFT MARKED WITH CONES WEF 1206251530<br>!ENM 04/002 ENM OBST FOUR WIND TURBINES 164 (161 AGL) 2 W WEF 1104082330                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| <b>Temperature:</b> _____ (C)<br>or <u>55</u> (F)<br><br><b>Altimeter Setting:</b> <u>29.92</u> in. HG<br>or _____ MB<br><br><b>Density Altitude:</b> _____ ft<br><br><b>Dew Point:</b> _____ (C)<br>or <u>45</u> (F)                                                                                                                                                                                                                                                                                                                             |                                                                                                   | <b>Icing Forecast</b><br><table style="width: 100%; border: none;"> <tr> <td style="text-align: center;"><b>Amount</b></td> <td style="text-align: center;"><b>Type</b></td> </tr> <tr> <td> <input checked="" type="checkbox"/> None    <input type="checkbox"/> Moderate<br/> <input type="checkbox"/> Trace    <input type="checkbox"/> Severe<br/> <input type="checkbox"/> Light             </td> <td> <input type="checkbox"/> Rime<br/> <input type="checkbox"/> Clear<br/> <input type="checkbox"/> Mixed             </td> </tr> </table> |             | <b>Amount</b>                                                                                                                                                                  | <b>Type</b>                                                                                       | <input checked="" type="checkbox"/> None <input type="checkbox"/> Moderate<br><input type="checkbox"/> Trace <input type="checkbox"/> Severe<br><input type="checkbox"/> Light                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Rime<br><input type="checkbox"/> Clear<br><input type="checkbox"/> Mixed |
| <b>Amount</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Type</b>                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| <input checked="" type="checkbox"/> None <input type="checkbox"/> Moderate<br><input type="checkbox"/> Trace <input type="checkbox"/> Severe<br><input type="checkbox"/> Light                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Rime<br><input type="checkbox"/> Clear<br><input type="checkbox"/> Mixed |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| <b>Icing Actual</b><br><table style="width: 100%; border: none;"> <tr> <td style="text-align: center;"><b>Amount</b></td> <td style="text-align: center;"><b>Type</b></td> </tr> <tr> <td> <input checked="" type="checkbox"/> None    <input type="checkbox"/> Moderate<br/> <input type="checkbox"/> Trace    <input type="checkbox"/> Severe<br/> <input type="checkbox"/> Light             </td> <td> <input type="checkbox"/> Rime<br/> <input type="checkbox"/> Clear<br/> <input type="checkbox"/> Mixed             </td> </tr> </table> |                                                                                                   | <b>Amount</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>Type</b> | <input checked="" type="checkbox"/> None <input type="checkbox"/> Moderate<br><input type="checkbox"/> Trace <input type="checkbox"/> Severe<br><input type="checkbox"/> Light | <input type="checkbox"/> Rime<br><input type="checkbox"/> Clear<br><input type="checkbox"/> Mixed | <b>Type of Precipitation</b> <i>(Check all that apply)</i><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Drizzle<br><input type="checkbox"/> Rain <input type="checkbox"/> Ice Pellets<br><input type="checkbox"/> Snow <input type="checkbox"/> Snow Pellets<br><input type="checkbox"/> Hail <input type="checkbox"/> Snow Grains<br><input type="checkbox"/> Rain Showers <input type="checkbox"/> Ice Crystals<br><input type="checkbox"/> Freezing Rain <input type="checkbox"/> Ice Pellets Shower<br><input type="checkbox"/> Snow Shower <input type="checkbox"/> Freezing Drizzle<br><br><b>Intensity of Precipitation</b><br><input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy |                                                                                                   |
| <b>Amount</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Type</b>                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| <input checked="" type="checkbox"/> None <input type="checkbox"/> Moderate<br><input type="checkbox"/> Trace <input type="checkbox"/> Severe<br><input type="checkbox"/> Light                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Rime<br><input type="checkbox"/> Clear<br><input type="checkbox"/> Mixed |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             |                                                                                                                                                                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |

### Pilot "A" Responsibilities at the Time of Accident/Incident

### Pilot "A" Identification

Certificate Number [REDACTED]

Used ☒ Yes ☐ No  
Available ☒ Yes ☐ No

04/12/2012  
mm/dd/yyyy

**MUST WEAR LENSES TO CORRECT VISION**

NONE

Make: CESSNA  
Model: 207

☒ Instrument Airplane  
☐ Instrument Helicopter  
☐ Helicopter  
☐ Glider  
☐ Sport

NONE

NONE

7

| <b>PILOT "B" INFORMATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------|-------------------------------------------------------------|--------------|-------------------|------------------------|----------------------|-------|------------|--|------------|--------|------------------|--------|-----------|------------|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|--|-----------------|--|--|--|--|--|--|--|--|--|--|--------------|--|--|--|--|--|--|--|--|--|--|--------------|--|--|--|--|--|--|--|--|--|--|---------------|--|--|--|--|--|--|--|--|--|--|
| <b>Pilot "B" Responsibilities at the Time of Accident/Incident</b><br><input type="checkbox"/> Pilot <input type="checkbox"/> Co-Pilot <input type="checkbox"/> Student Pilot <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Check Pilot <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Other Flight Crew                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Pilot "B" Identification</b><br><div style="display: flex; justify-content: space-between;"> <div>           First Name: _____<br/>           Middle Initial: _____<br/>           Last Name: _____         </div> <div>           City: _____<br/>           State: _____ ZIP: _____<br/>           Country: _____         </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>Age at time of Accident/Incident: _____</div> <div>Date of Birth: _____<br/><small>mm/dd/yyyy</small></div> <div>Certificate Number: _____</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Degree of Injury</b><br><input type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                                                                                                                                                                                               | <b>Seat Occupied</b><br><input type="checkbox"/> Left <input type="checkbox"/> Front <input type="checkbox"/> Unknown<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single |                                                                                                                                                                                                          |                                                                                                                                                                                      | <b>Seat Belt</b><br>Used <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Available <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                | <b>Shoulder Harness</b><br>Used <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Available <input type="checkbox"/> Yes <input type="checkbox"/> No |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Pilot Certificate(s) (Check all that apply)</b><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None    <input type="checkbox"/> Student<br/> <input type="checkbox"/> Private    <input type="checkbox"/> Flight Instructor         </div> <div> <input type="checkbox"/> Recreational    <input type="checkbox"/> Commercial<br/> <input type="checkbox"/> Sport    <input type="checkbox"/> Airline Transport         </div> <div> <input type="checkbox"/> Flight Engineer    <input type="checkbox"/> Foreign<br/> <input type="checkbox"/> U.S. Military         </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Principal Occupation</b><br><input type="checkbox"/> Pilot<br><input type="checkbox"/> Other<br><input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              | <b>Medical Certificate</b><br><input type="checkbox"/> None <input type="checkbox"/> Class 3<br><input type="checkbox"/> Class 1 <input type="checkbox"/> Driver's License (Sport Pilot only)<br><input type="checkbox"/> Class 2 <input type="checkbox"/> Unknown                                                            |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          | <b>Medical Certificate Validity</b><br><input type="checkbox"/> Without limitations/waivers<br><input type="checkbox"/> With limitations/waivers<br><input type="checkbox"/> Unknown |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Date of Last Medical</b><br><div style="text-align: right;"><small>mm/dd/yyyy</small></div> |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Limitations</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Waivers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> _____<br><div style="text-align: right;"><small>mm/dd/yyyy</small></div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          | <b>Flight Review Aircraft</b><br>Make: _____<br>Model: _____                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Airplane Rating(s) (Check all that apply)</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Single-Engine Land<br><input type="checkbox"/> Single-Engine Sea<br><input type="checkbox"/> Multiengine Land<br><input type="checkbox"/> Multiengine Sea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              | <b>Other Aircraft Rating(s) (Check all that apply)</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Airship<br><input type="checkbox"/> Free Balloon<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |                                                                                                                                                                                                                                                          | <b>Instrument Rating(s) (Check all that apply)</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Airplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |                                                                                                                                                                                      | <b>Instructor Rating(s) (Check all that apply)</b><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None<br/> <input type="checkbox"/> Airplane Single-Engine<br/> <input type="checkbox"/> Airplane Multi-Engine<br/> <input type="checkbox"/> Gyroplane<br/> <input type="checkbox"/> Powered Lift         </div> <div> <input type="checkbox"/> Instrument Airplane<br/> <input type="checkbox"/> Instrument Helicopter<br/> <input type="checkbox"/> Helicopter<br/> <input type="checkbox"/> Glider<br/> <input type="checkbox"/> Sport         </div> </div> |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Type Ratings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      | <b>Student Endorsements (Include dates)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2" style="text-align: left; padding: 2px;">Flight Time (enter appropriate number of hours in each box)</th> <th rowspan="2" style="padding: 2px;">All Aircraft</th> <th rowspan="2" style="padding: 2px;">This Make &amp; Model</th> <th rowspan="2" style="padding: 2px;">Airplane Single Engine</th> <th rowspan="2" style="padding: 2px;">Airplane Multiengine</th> <th rowspan="2" style="padding: 2px;">Night</th> <th colspan="2" style="padding: 2px;">Instrument</th> <th rowspan="2" style="padding: 2px;">Rotorcraft</th> <th rowspan="2" style="padding: 2px;">Glider</th> <th rowspan="2" style="padding: 2px;">Lighter Than Air</th> </tr> <tr> <th style="padding: 2px;">Actual</th> <th style="padding: 2px;">Simulated</th> </tr> </thead> <tbody> <tr> <td style="text-align: left; padding: 2px;">Total Time</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 2px;">Pilot in Command (PIC)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 2px;">Time as Instructor</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 2px;">This Make/Model</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 2px;">Last 90 Days</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 2px;">Last 30 Days</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 2px;">Last 24 Hours</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table> |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  | Flight Time (enter appropriate number of hours in each box) | All Aircraft | This Make & Model | Airplane Single Engine | Airplane Multiengine | Night | Instrument |  | Rotorcraft | Glider | Lighter Than Air | Actual | Simulated | Total Time |  |  |  |  |  |  |  |  |  |  | Pilot in Command (PIC) |  |  |  |  |  |  |  |  |  |  | Time as Instructor |  |  |  |  |  |  |  |  |  |  | This Make/Model |  |  |  |  |  |  |  |  |  |  | Last 90 Days |  |  |  |  |  |  |  |  |  |  | Last 30 Days |  |  |  |  |  |  |  |  |  |  | Last 24 Hours |  |  |  |  |  |  |  |  |  |  |
| Flight Time (enter appropriate number of hours in each box)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | All Aircraft | This Make & Model                                                                                                                                                                                                                                                                                                             | Airplane Single Engine                                                                                                                                                                                                                                   | Airplane Multiengine                                                                                                                                                                                     | Night                                                                                                                                                                                | Instrument                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                | Rotorcraft                                                                                                                                                     | Glider | Lighter Than Air |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      | Actual                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Simulated                                                                                      |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Total Time                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |

**ADDITIONAL FLIGHT CREW MEMBERS (Exclusive of cabin attendants; complete the following information)**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                           |                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Pilot Name and Address</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                       |                                                                           | <b>Degree of Injury</b><br><input type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                              |
| <b>Pilot Certificate(s) (Check all that apply)</b><br><input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military |                                                                           | <b>Seat Occupied</b><br><input type="checkbox"/> Left <input type="checkbox"/> Front<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single<br><input type="checkbox"/> Unknown |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                  | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs |                                                                                                                                                                                                                                                             |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                           |                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Pilot Name and Address</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                       |                                                                           | <b>Degree of Injury</b><br><input type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                              |
| <b>Pilot Certificate(s) (Check all that apply)</b><br><input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military |                                                                           | <b>Seat Occupied</b><br><input type="checkbox"/> Left <input type="checkbox"/> Front<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single<br><input type="checkbox"/> Unknown |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                  | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs |                                                                                                                                                                                                                                                             |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                           |                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Pilot Name and Address</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                       |                                                                           | <b>Degree of Injury</b><br><input type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                              |
| <b>Pilot Certificate(s) (Check all that apply)</b><br><input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military |                                                                           | <b>Seat Occupied</b><br><input type="checkbox"/> Left <input type="checkbox"/> Front<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single<br><input type="checkbox"/> Unknown |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                  | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs |                                                                                                                                                                                                                                                             |

**PASSENGER(S)/OTHER PERSONNEL (include flight attendants; continue on separate sheet if necessary)**

| Name and Address                                                                                                  | Seat | Crew                     | Non-Revenue              | Revenue                  | Non-Occupant             | FAA                      | Fatal                    | Serious Injury           | Minor Injury             | No Injury                | Unknown                  |
|-------------------------------------------------------------------------------------------------------------------|------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____ |      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____ |      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____ |      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____ |      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____ |      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____ |      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____ |      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____ |      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**NARRATIVE HISTORY OF FLIGHT (Place type or print in ink)**

Describe what occurred in chronological order, including circumstances leading to and nature of accident/incident. Describe terrain and include wreckage distribution sketch if pertinent. Attach extra sheets if needed. State time and point of departure, intended destination, and services obtained.

I was at 200 feet agl on a course that would take me from Kotlik to Emmonak. I flew over a portion of the river that is there and turned to fly over the river. I reset my power to 23 inches manifold pressure and 2300 RPM during which I glanced into the cockpit for a moment. During that time the aircraft descended and made contact with the surface of the river. I applied light back pressure to climb to 500 feet AGL and then proceeded directly to the nearest airport, PFKO (Kotlik, Alaska). As I was climbing I made an assessment of engine instruments and flying characteristics and decided to continue directly to Kotlik. I entered the traffic pattern and setup the aircraft for landing. On landing the propeller and nose of the aircraft struck the ground and I immediately pulled the mixture to idle cutoff position. I then secured the aircraft by confirming that I had indeed placed the mixture in idle cutoff position, throttle at idle, magnetos off, and master switch off. I also shutoff the ELT and then exited the aircraft to perform a post flight inspection to determine if the aircraft was leaking oil or fuel on the runway. Once I determined that no fluids were leaking I secured the aircraft and contacted my company

**RECOMMENDATION (How could this accident/incident have been prevented?)**

Operator/Owner Safety Recommendation

**ADDITIONAL INFORMATION** *(Please type or print in ink)*

Use this space if additional space is needed for any answers.

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE****Date of this Report**

07/16/2012

mm/dd/yyyy

**Signature and Name of Pilot/Operator**

Signature: \_\_\_\_\_

Type or Print Name: \_\_\_\_\_

**Signature and Name of Person Filing Report if Other than Pilot/Operator**

Signature: \_\_\_\_\_

Type or Print Name: AUSTIN ENGEBRETSON

Title: DIRECT OF OPERATIONS

**FOR NTSB USE ONLY****NTSB Accident/Incident No.**

ANC12CA067

**Reviewed by NTSB Regional Office**

Anchorage

**Name of Investigator**

Banning

**Date Report Received**

7/16/2012